Health Care Financing Administration

STRATEGIC PLAN

HCFA

Health Care Financing Administration

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Introduction

The end of the twentieth century presents a time of unparalleled change in our Nation's health care system. As new models of health care delivery systems continually evolve, and rapid advances in technology and communications revolutionize the provision of health care, so too must our Nation's largest health insurance programs adapt. The Health Care Financing Administration (HCFA) is responsible for overseeing the Medicare and Medicaid programs. Medicare and Medicaid have become indispensable programs for the most vulnerable segments of the population. For more than three decades, HCFA's programs have met the basic health care needs of elderly, disabled, and low-income Americans.

In addition to the Medicare and Medicaid programs, HCFA is responsible for the Clinical Laboratory Improvement Amendments (CLIA), the Health Insurance Portability and Accountability Act (HIPAA), including oversight for individual and small group market health insurance regulation, the State Children's Health Insurance Program (CHIP), and oversight of Medigap insurance. In carrying out all of these responsibilities, HCFA strives to be a leader in improving the delivery of cost-effective, appropriate, high quality health care for all of our beneficiaries, promoting and preserving beneficiary rights and protections, and in meeting the highest standards of administrative performance.

Through this Strategic Plan, HCFA sets forth its goals and objectives for carrying out this work over the next six years in conjunction with the Strategic Plan of the Department of Health and Human Services. HCFA's Strategic Plan begins with a brief overview of the mission, vision, goals, and objectives of the Agency. It then provides background information on HCFA and its programs and the beneficiaries served by these programs. Next, the Plan delineates the key external factors that might affect achievement of our strategic goals and objectives. In the years ahead, HCFA will need to carry out its mandate to ensure access to high quality health care for the elderly, persons with disabilities, and certain low income populations in a rapidly changing health care environment. Like other purchasers of health care, HCFA's future success will depend on its ability to adapt to changes affecting HCFA programs.

The Plan then describes the Agency's participation in the Department's strategic planning process, as well as HCFA's strategic planning process. The use of research and evaluation in our strategic planning and a schedule of future program evaluations follows. As required by the Government Performance and Results Act of 1993 (GPRA), HCFA prepares an Annual Performance Plan to complement and support the Agency's fiscal year budget request. The performance plan builds on HCFA's strategic planning process by specifying measurable performance goals and indicators that describe the intended progress in a particular fiscal year towards the strategic plan goals and objectives. Given the close connection between the Annual Performance and Strategic Plans, a section has been devoted to describing this relationship. The balance of the Plan details the Agency's mission, vision, strategic goals and objectives, possible strategies for accomplishing the goals and objectives, and HCFA's operating principles.

Overview

MISSION

"We assure health care security for beneficiaries."

VISION

"In the stewardship of our programs, we lead the Nation's health care system toward improved health for all."

GOALS

- Protect and improve beneficiary health and satisfaction.
- Promote the fiscal integrity of HCFA programs.
- Purchase the best value health care for beneficiaries.
- Promote beneficiary and public understanding of HCFA and its programs.
- Foster excellence in the design and administration of HCFA's programs.
- Provide leadership in the broader public interest to improve health.

OBJECTIVES

Customer Service

CS-1: Improve beneficiary satisfaction with programs, services, and care.
CS-2: Enhance beneficiary program protections.
CS-3: Increase the usefulness of communications with beneficiaries.
CS-4: Increase the usefulness of communications with constituents, partners, and stakeholders.
CS-5: Ensure that programs and services respond to the health care needs of beneficiaries.

Quality of Care

QC-1: Improve health outcomes.
QC-2: Improve access to services for underserved and vulnerable beneficiary populations.
QC-3: Protect beneficiaries from substandard care.

Program Administration

PA-1: Build a high quality, customer-focused team.
PA-2: Enhance program safeguards.
PA-3: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds.
PA-4: Increase public knowledge of the financing and delivery of health care.
PA-5: Improve HCFA's management of information systems/technology.

Background

HCFA and its Programs

The Health Care Financing Administration (HCFA) was created in 1977 to bring together, under one leadership, the two largest Federal health care programs—Medicare and Medicaid. These two entitlement programs, which finance health care for elderly, disabled,[1] and low-income persons, were created simultaneously by 1965 amendments to the Social Security Act (Titles XVIII and XIX). Medicare was seen as an extension of the social insurance concept of the Social Security cash benefits programs and initially was administered by the Social Security Administration. Medicaid was conceived as a Federal/State partnership in both policy setting and funding and as part of the social safety net for eligible low-income persons. Prior to 1977, it was administered by the Social and Rehabilitation Service along with certain other income-related programs. With the creation of HCFA, certain administrative and programmatic efficiencies were anticipated, such as the opportunity to establish uniform conditions of participation for facilities under both Medicare and Medicaid.

During the two decades since HCFA was established, the Agency's statutory mission has grown beyond administration of Medicare and Medicaid to include responsibility for Federal oversight of clinical laboratories under the Clinical Laboratory Improvement Amendments, oversight of Medigap insurance, and, under the Health Insurance Portability and Accountability Act, for individual and small group market health insurance regulation. The Balanced Budget Act of 1997 (BBA) made the most extensive changes to Medicare in the Agency's history. In addition, BBA created a new program, the State Children's Health Insurance Program (CHIP), to expand health insurance coverage to low-income children.

Further, the dimensions and nature of the Medicare and Medicaid programs have evolved significantly. Major changes in Medicare include:

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[1]Individuals with end-stage renal disease are also eligible for Medicare benefits.

1972 Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD).

1982 The Tax Equity and Fiscal Responsibility Act made it easier and more attractive for health maintenance organizations to contract with the Medicare program, so that by mid-year 1998 approximately 17% of beneficiaries had enrolled in managed care plans. In addition, the Act expanded HCFA's quality oversight efforts through Peer Review Organizations (PROs).

1983 An inpatient acute hospital prospective payment system, based on patients' diagnoses, was adopted to replace cost-based payments.

1987 The Omnibus Budget Reconciliation Act of 1987 (OBRA87) strengthened the protections for residents of nursing homes.

1989 A new fee schedule for physician and other professional services was approved.

1997 The Balanced Budget Act of 1997 contained some of the most significant changes to the program in Medicare's history, including for example:
—establishing an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process;
—requiring HCFA to develop and implement new prospective payment systems for many Medicare services including home health, skilled nursing facilities, hospital outpatient departments, and outpatient rehabilitation services;
—extending the life of the Medicare Trust Fund for the short term and establishing a commission to plan for the future of the program;
—providing a broad range of beneficiary protections;
—expanding preventive benefits; and
—testing other innovative approaches to payment and service delivery through research and demonstrations.

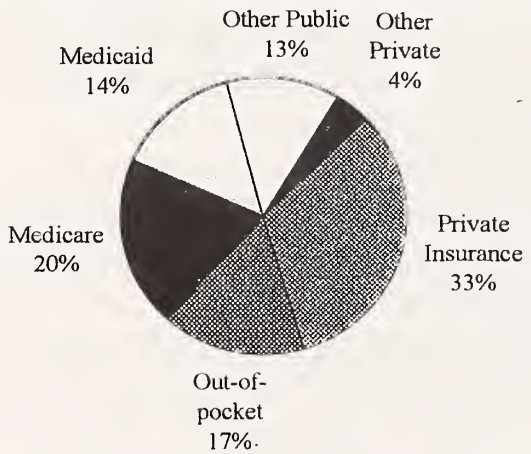
Particularly over the past 5 years, the Medicaid program has seen States begin to make extensive use of statutory waiver authorities to experiment with new health care delivery systems and to expand eligibility for Medicaid beneficiaries. The BBA also significantly expanded State flexibility in the design and operation of new ways to serve low-income children and families.

HCFA is the largest purchaser of health care in the United States, providing health care coverage for an estimated 71.2 million (FY 2000)[2] beneficiaries or nearly one out of four Americans. Of these beneficiaries, approximately 6 million are "dually eligible" and served by both Medicare and Medicaid. HCFA programs account for more than one of every three dollars spent on health care in the U.S. economy (Figure 1) and represent the third largest outlay of the Federal Government, behind only Social Security and interest on the national debt.

Figure 1

Sources of Funds, 1996

34 Percent of Health Spending Comes from Medicare and Medicaid



Source: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group

[2]This figure counts each Medicare and Medicaid beneficiary only once, even if he or she is receiving both Medicare and Medicaid benefits.

To carry out these responsibilities, HCFA works in partnership with many other organizations and individuals. HCFA interacts with State, territorial, and Tribal governments, hundreds of contractors (including the Medicare carriers and fiscal intermediaries and Peer Review Organizations), thousands of providers of care (including health plans, practitioners, and facilities), in addition to beneficiaries and their families. HCFA employs about 4,000 persons in locations around the country. These employees work in partnership with:

- Close to 60 private sector contractors, who will process and pay almost 1 billion Medicare claims in fiscal year 2000 and ensure the accuracy of the payments.

- 34,000 employees working for State agencies who will pay over 1 billion Medicaid benefit claims and process eligibility claims.

- 6,000 State employees who will survey more than 39,000 thousand nursing facilities, home health agencies, some hospitals, and other non-long-term care facilities for quality and safety standards.

- Private sector agents who will conduct research and demonstration projects to advance important aspects of health care, including the development of new payment systems, delivery systems, and the improvement of quality.

HCFA staff perform an array of critical functions necessary for program administration, such as providing funds to Medicare contractors; developing Medicare payment policies; managing programs to fight waste, fraud, and abuse; maintaining the operating systems that support Medicare payments; developing more efficient operating systems; developing cost effective health care purchasing approaches; overseeing Clinical Laboratory Improvement Amendments activities; monitoring contractor and provider performance; assisting States with Medicaid issues; providing actuarial estimates for the Medicare trust funds; promoting and preserving beneficiary rights and protections; and disseminating information to Congress, beneficiaries, and the general public.

Focus on Beneficiaries

HCFA's internal strategic planning process (begun in 1994), the enactment of the Government Performance and Results Act (GPRA), and other HHS and government-wide initiatives have all emphasized the themes of accountability/stewardship and a renewed focus on the "customer." In HCFA's case, this resulted in a renewed Agency commitment to beneficiaries as the ultimate focus of all HCFA activities, expenditures, and policies. Part of serving beneficiaries effectively is knowing their characteristics and needs, both now and in the future. For example,

- Eighty percent of Medicare fee-for-service dollars are spent on behalf of persons with annual incomes of $25,000 or less, making many beneficiaries sensitive to even small increases in their out-of-pocket costs for care.

- Two groups of beneficiaries with extensive health care needs—those over age 85 and those with end stage renal disease—are the two fastest growing segments of the Medicare population.

- The future Medicare beneficiary population will be more diverse, including many ethnic and racial groups, languages, and cultures.

- While the Medicaid population is diverse, it is predominately children and their families, in fact, though, the elderly and disabled on Medicaid account for more than two-thirds of program expenditures.

- Beneficiaries eligible for both Medicare and Medicaid comprise one of the most vulnerable populations in either program; these individuals are low income and include a disproportionate share of the frail elderly and non-elderly individuals with severe mental and physical disabilities.

- Over 11 million of our Nation's children are currently uninsured. Approximately 4.7 million uninsured children are eligible for, but not enrolled in, Medicaid.

- The State Children's Health Insurance Program (CHIP) gives States the option to create or expand a separate State program, expand Medicaid, or a combination of these two approaches to expand coverage to uninsured, low-income children. Many of these children have working parents who earn too much to qualify for Medicaid, but too little to afford private insurance.

Knowledge about beneficiary characteristics and needs is essential to the achievement of HCFA's goals and is therefore an important part of HCFA's strategic planning process.

Key External Factors

Another important theme emphasized in this updated Plan is a heightened awareness of change in the larger health care environment in which HCFA operates and the need for flexible responses to those changes. In the years ahead, HCFA will need to carry out its mandate to ensure access to high quality health care for the elderly, persons with disabilities, and certain low-income populations in this changing environment.

Public Purchaser

HCFA's interdependence with a changing health care environment presents both challenges and opportunities with respect to the achievement of the Agency's strategic goals and objectives. Our strategic goals have been developed based on our understanding of the health care system and our role in that system. Once our strategic direction is defined, we look for ways of accomplishing goals and objectives that capitalize on shared interests and the potential for fruitful collaboration across the health care system. For example, recent developments in methods of quality measurement and reporting for managed care plans have come about as a result of innovative public/private partnerships. However, as a government agency, HCFA operates in a framework that differs from private sector purchasers of health care. While, HCFA has identified as one of its goals, "Purchase the best value health care for beneficiaries," the fact that we must operate within current statutory authorities means that some shifts towards this direction may take longer or require a change in the underlying statute.

HCFA and its Partners

HCFA accomplishes its mission by working with and through others—not in isolation. HCFA employees are only a small portion of a large, complex network that makes our programs work successfully. HCFA employees, HCFA agents, other HHS Agencies, other Federal Agencies, States, territories, and Tribes, providers of care, beneficiary and consumer organizations, accrediting bodies, researchers, and others work together to help ensure that our beneficiaries have access to high quality care. HCFA's ability to accomplish many of its strategic goals and objectives and performance goals is intricately related to and dependent upon the performance of different components in this complex network.

HCFA's reliance on partners is one of its defining characteristics. Working in partnership leverages HCFA resources, which is ultimately in the beneficiaries' best interest. Interdependence means working together to establish and accomplish mutual goals. For example, the Medicaid program is a Federal/State partnership that is primarily administered by the States. In order to develop Medicaid performance goals, HCFA is consulting with the States regarding performance goals and data sources to measure progress toward those goals. Another example of HCFA's reliance on partners is with the State Health Insurance Assistance Grants Program (SHIP). HCFA depends on these State programs to provide information, counseling, and assistance to beneficiaries on Medicare and Medicaid matters as well as Medicare supplemental policies, long-term care insurance, managed care options, and other health insurance benefit information.

Future Challenges

Millennium Compliance

Computer systems around the world face major challenges in being able to process correctly after December 31, 1999. Ensuring that all HCFA data systems are millennium compliant is one of HCFA's top priorities. HCFA employs a variety of information systems to carry out its function of providing for the health care of its beneficiaries, both internally and externally in the contractor community including State systems for the administration of Medicaid.

Millennium compliance is essential in order to avoid significant disruptions of the programs' payments and other key outputs of the Agency due to the inability of HCFA's computer systems and those of HCFA contractors to process date sensitive information. HCFA must supervise the analysis, renovation, testing, and certification of mission critical internal HCFA systems and the systems of the Medicare contractors and the standard system maintainers to ensure millennium compliance.

Since many of the information systems that process Medicare claims and provide for payment are owned or operated by fiscal intermediaries (FIs) and carriers, HCFA has less direct control over these systems and is therefore somewhat dependent on our FIs and carriers for accomplishing our performance goal of millennium compliance. HCFA has been and will continue to work with our FIs and carriers to ensure that their Medicare systems are millennium compliant. HCFA is also working with the States to help State Medicaid programs meet Year 2000 requirements. The millennium challenges are pertinent to our goal, "Foster excellence in the design and administration of our program."

New Statutory Mandates

Enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 and the Balanced Budget Act (BBA) in 1997 have made significant changes to the statutory framework within which HCFA operates. In many respects, these new laws will provide opportunities for HCFA to move forward toward strategic goals. However, the requirement to implement such a wide range of new program activities in a relatively short time will cause the Agency to focus its resources on immediate implementation efforts.

HIPAA moves HCFA into new roles clearly outside the scope of administering Medicare, Medicaid, and the Clinical Laboratory Improvement Amendments (CLIA). HCFA will play a part in regulation of the broader health insurance market in order to preserve coverage for individuals who would otherwise be uninsured or underinsured and in the implementation of the administrative simplification provisions of HIPAA which call for a single set of national standards for electronic data transactions. The BBA creates an array of new managed care and other health plan choices for Medicare beneficiaries and establishes a coordinated open enrollment process. These new choices require HCFA to undertake the most extensive beneficiary education program in the Agency's history. It also requires HCFA to develop and implement new prospective payment systems for many Medicare services to help further restrain the rate of growth of health care spending and foster incentives for more appropriate use of scarce program resources. Furthermore, BBA expands health insurance to many uninsured children through the Children's Health Insurance Program (CHIP).

Both HIPAA and BBA impose major new workloads for HCFA and will require a concentrated effort to effectively manage resources. This challenge will be especially relevant to HCFA's goals, "Purchase the best value health care for beneficiaries" and "Foster excellence in the design of our programs."

Program Integrity

The size and scope of HCFA's programs, measured both in dollars and in numbers of persons served, necessitate an emphasis on prevention and detection of waste, fraud, and abuse that divert program dollars from their otherwise intended purposes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA) gave HCFA new tools and resources for stepping up program integrity activities. In order for Medicare, Medicaid, and HCFA's other programs to remain solvent and strong, HCFA must take effective measures to prevent improper or fraudulent claims, which strain the fiscal and personnel resources of the programs. While ensuring that program dollars are appropriately spent, HCFA must also ensure that pursuit of efficiency and cost-effectiveness does not compromise access or health care quality.

Operation Restore Trust (ORT) is an example of the collaborative efforts by HCFA, the Office of Inspector General, Medicare contractors, State Medicaid Agencies, Peer Review Organizations, the Administration on Aging, the Federal Bureau of Investigation, and the Department of Justice to detect and deter home health, skilled nursing facilities, and durable medical equipment waste, fraud, and abuse.

Changes in health care delivery, such as increasing managed care enrollment in Medicare and Medicaid, and new coverage (e.g., new preventive benefits) and payment policies (e.g., new prospective payment systems for skilled nursing facilities and home health) introduce new program designs for which appropriate program integrity protections must be in place. These new designs bring shifting incentives for waste, fraud, and abuse, such as accepting payments without rendering services or providing poor quality health care. These program integrity challenges are important factors in HCFA's goal, "Promote the fiscal integrity of HCFA programs."

Changes in Health Care Delivery

The challenges encountered by HCFA in administering the Agency's programs are not unlike those faced by private sector payers. All types of payers and insurers in the U.S. health care system are aware of the need to contain costs, contract with managed care organizations, and to develop prudent purchasing approaches. From 1969 through 1997, spending growth per enrollee in Medicare has grown on average at comparable annual rates to private insurance benefits. Much attention has been focused on 1994 and 1995, when trends in growth rates for these two payers suddenly diverged—with Medicare per enrollee spending in 1995 changing very little from past rates, and private spending significantly decelerating. However, as a result of the Balanced Budget Act, growth rates in Medicare per enrollee spending are expected to decline, and there are now reports indicating an increase in per capita spending growth by private payers.[3]

In the early 1990s Medicaid spending played a major role in the strong growth of public spending for medical care. By 1996, however, growth in Federal and State Medicaid spending dropped to the lowest annual growth (5.3%) since the program's inception. In large part, this slowdown is attributable to low rates of medical price inflation that dampened growth in spending per recipient, legislation tightening policy on disproportionate share hospital payments and provider-based taxes and voluntary donations, as well as the generally favorable economic conditions that reduced the number of people eligible for Medicaid.

The growth of managed care delivery arrangements in the Nation during the 1990s has been enormous. More than 100 million Americans are now enrolled in some form of managed care. The percentage of workers in private sector firms enrolled in managed care has risen from 29% in 1988 to 75% in 1996. At the same time, employer-based health insurance coverage

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[3]Towers Perrin Health Care Cost Survey reports that the costs of large employers' health benefit plans are expected to rise 4% in 1998, up from a 3% increase in 1997. The survey respondents were predicting steeper increases for 1999, on the order of 7% for managed care plans and 9% for indemnity health insurance. Also, the Office of Personnel Management (OPM) has reported an 8.5% average premium growth increase for 1998 premiums and an average 10.2% increase for 1999 for plans offered to Federal workers.

has eroded, contributing to the growth of the uninsured and underinsured populations which stands at an estimated 41.7 million (1996). The change to managed care is also evident in HCFA's programs. Some 15.3 million Medicaid beneficiaries were enrolled in managed care plans in 1997, accounting for 47.8% of Medicaid beneficiaries, with an even greater proportion of mothers and children enrolled in managed care. Medicare, too, has seen growth in enrollment so that, as of 1998, over 17% of beneficiaries are enrolled in managed care plans. Under current projections, this will grow to about 28% by 2002, in large part due to the choices available to Medicare beneficiaries under the Balanced Budget Act of 1997 (BBA). In the short-run, we anticipate only a modest rise in available choices, as the health care industry attempts to understand the implications of new payment and delivery arrangements under the BBA.

One of the basic operating principles in HCFA's strategic plan is that beneficiaries are our primary customers and that HCFA's "reason for being" is to respond to beneficiaries' health care needs. Beneficiary satisfaction with the health care services they receive is a critical outcome-oriented measure of how well we are carrying out this basic principle. In addition, research has shown that patient satisfaction is an important factor in compliance with medical regimens, maintaining continuity of care, and other behavioral health issues. Therefore, HCFA plans to utilize various data sources such as the Consumer Assessment of Health Plans Study (CAHPS[4]) in both the managed care and fee-for-service settings to better understand the health care needs of our beneficiaries. Through the Health Employer Data and Information Set (HEDIS) Health of Senior (HOS) measure, HCFA plans to assess beneficiaries' functional status over time.

Further, the Agency must develop purchasing strategies for both fee-for-service and managed care environments. This is especially the case given the enactment of BBA in 1997 permitting new categories of coordinated care plans to contract with Medicare. In addition, it is important to remember that the majority of Medicare beneficiaries remain in fee-for-service arrangements, and HCFA must develop purchasing approaches for fee-for-service that are both effective and up-to-date.

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[4]CAHPS was developed by the Agency for Health Care Policy and Research.

Technological Advances

Technological advances are often spectacular in their character and speed of diffusion. No doubt, advances in transplants, laser technology, nuclear medicine, and genetically-based treatments will change the nature of health care. New technologies also raise coverage, payment, and quality issues. HCFA has a responsibility, within the limits of law and regulation, to ensure that beneficiaries have access to new technologies as they emerge and are supported by authoritative scientific evidence. Technology is of particular importance to our strategic goal, "Protect and improve beneficiary health and satisfaction."

Technological advances are one of the primary reasons health care costs have risen faster than the general consumer price index over the last three decades. HCFA has a responsibility to ensure that new technologies covered by Medicare are reasonable and necessary. Given that it is difficult to predict what types of advances are likely to arise, the dilemma of the adequacy of data to make evidence-based coverage decisions for some new technologies and services, whether these advances will make particular services or diseases more (or less) costly, and the rapid evolution of medical and information technology, advances in technology will continue to pose a particular challenge for HCFA in the coming years. HCFA is working to improve its coverage process by making it more open. This includes establishing an advisory committee process that is compliant with the Federal Advisory Committee Act. Among other things, the committee will provide independent expertise and technical assistance to HCFA in its review of coverage policy for new and existing technologies and procedures.

Demographic Changes

The demographic changes that will occur as the post-World War II "baby boom" generation ages are well known. Past variation in birth rates, together with steady improvement in life expectancy, are expected to result in major increases in the number of older persons relative to those of working age beginning in 2010. Current analyses based on that projection predict that, with the expected drop in the ratio of active workers to retirees, payroll tax revenues will not keep pace with expected Medicare expenditures. Also, a larger number of elderly beneficiaries has implications for Medicaid as well as Medicare, in part because of Medicaid's role in financing long-term care services.

The "demographic problem" of financing health care in the Medicare and Medicaid programs needs to be evaluated in the context of the very much altered economic and demographic circumstances of the twenty first century. While considering the future of the programs in this broader context, we must keep in mind that, *whatever* happens, the fact remains that there will be a substantial proportion of the future population that is aged and will require medical care—care that will have to be paid for one way or another.

Two ways that HCFA is working to address the demographic impacts on the programs are through the provisions in the BBA and by supporting the National Bipartisan Commission on the Future of Medicare. The BBA contains provisions that serve to extend the life of the Medicare Hospital Insurance Trust Fund and gives the Commission, and subsequently the Congress, time to consider longer-term solutions. HCFA will work with the National Bipartisan Commission which is charged with reviewing and analyzing the program's financial condition, identifying problems that threaten its fiscal integrity, and preparing recommendations to address its long-term financial challenges.

Strategic Planning Process

Participation in the Department's Strategic Planning Process

Under the Government Performance and Results Act of 1993 (GPRA), the Department of Health and Human Services (HHS) prepared a Department-wide Strategic Plan that covers all Operating Divisions. HCFA actively participated in the Department's strategic planning process begun in 1994. HCFA's Strategic Plan dovetails with that of HHS, as it was submitted to the Congress in September 1997. In particular, HCFA's Strategic Plan supports:

HHS Goal 2: Improve the economic and social well-being of individuals, families, and communities of the United States.

HHS Goal 3: Improve access to health services and ensure the integrity of the Nation's health entitlement and safety net programs.

HHS Goal 4: Improve the quality of health care and human services.

HHS Goal 6: Strengthen the Nation's health sciences research enterprise and enhance its productivity.

In the HHS Plan, several strategic objectives for accomplishing the HHS goals specifically relate to HCFA's objectives (Table 1). As shown in Table 1, the majority of HCFA's objectives link to the HHS objectives under goals 3 and 4. The HHS Plan details the objectives as well as possible strategies for achieving the Department objectives.

Table 1. Link of HHS Strategic Plan Objectives and HCFA Strategic Plan Objectives

HHS Objective	HCFA Objective
HHS Objective 2.5: Increase opportunities for seniors to have an active and healthy aging experience.	**Customer Service-1**: Improve beneficiary satisfaction with programs, services, and care. **Customer Service-5**: Ensure that programs and services respond to the health care needs of beneficiaries.
HHS Objective 2.6: Expand access to consumer-directed, home and community-based long term care and health services.	**Customer Service-5**: Ensure that programs and services respond to the health care needs of beneficiaries.
HHS Objective 3.1: Increase the percentage of the Nation's children and adults who have health insurance coverage.	**Quality of Care-2**: Improve access to services for underserved and vulnerable beneficiary populations.
HHS Objective 3.4: Protect and improve beneficiary health and satisfaction in Medicare and Medicaid.	**Customer Service-1**: Improve beneficiary satisfaction with programs, services, and care. **Customer Service-2**: Enhance beneficiary program protections. **Customer Service-3**: Increase the usefulness of communications with beneficiaries. **Customer Service-4**: Increase the usefulness of communications with constituents, partners, and stakeholders. **Customer Service-5**: Ensure that programs and services respond to the health care needs of beneficiaries. **Quality of Care-1**: Improve health outcomes. **Quality of Care-2**: Improve access to services for underserved and vulnerable beneficiary populations. **Quality of Care-3**: Protect beneficiaries from substandard care. **Program Administration-3**: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds. **Program Administration-4**: Increase public knowledge of the financing and delivery of health care. **Program Administration-5**: Improve HCFA's management of information systems/technology.
HHS Objective 3.5: Enhance the fiscal integrity of HCFA programs and ensure the best value health care for beneficiaries.	**Customer Service-2:** Enhance beneficiary program protections. **Customer Service-3:** Increase the usefulness of communications with beneficiaries. **Customer Service-4:** Increase the usefulness of communications with constituents, partners, and stakeholders. **Customer Service-5**: Ensure that programs and services respond to the health care needs of beneficiaries. **Program Administration-2:** Enhance program safeguards. **Program Administration-3:** Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds. **Program Administration-5:** Improve HCFA's management of information systems/technology.

Table 1. Link of HHS Strategic Plan Objectives and HCFA Strategic Plan Objectives

HHS Objective	HCFA Objective
HHS Objective 4.1: Promote the appropriate use of effective health services.	**Customer Service-1**: Improve beneficiary satisfaction with programs, services, and care. **Customer Service-2**: Enhance beneficiary program protections. **Customer Service-3**: Increase the usefulness of communications with beneficiaries. **Customer Service-5**: Ensure that programs and services respond to the health care needs of beneficiaries. **Quality of Care-1**: Improve health outcomes. **Quality of Care-3**: Protect beneficiaries from substandard care. **Program Administration-3**: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds.
HHS Objective 4.2: Reduce disparities in the receipt of quality health care services.	**Quality of Care-1**: Improve health outcomes. **Quality of Care-2**: Improve access to services for underserved and vulnerable beneficiary populations. **Customer Service-2**: Enhance beneficiary program protections.
HHS Objective 4.3: Increase consumers' understanding of their health care options.	**Customer Service-1**: Improve beneficiary satisfaction with programs, services, and care. **Customer Service-3**: Increase the usefulness of communications with beneficiaries. **Customer Service-4**: Increase the usefulness of communications with constituents, partners, and stakeholders. **Quality of Care-1**: Improve health outcomes.
HHS Objective 4.4: Improve consumer protection.	**Customer Service-2**: Enhance beneficiary program protections. **Quality of Care-3**: Protect beneficiaries from substandard care.
HHS Objective 6.4: Increase the understanding of and response to the major issues related to the quality, financing, cost, and cost-effectiveness of health care services.	**Customer Service-4**: Increase the usefulness of communications with constituents, partners, and stakeholders. **Customer Service-5**: Ensure that programs and services respond to the health care needs of beneficiaries. **Quality of Care-2**: Improve access to services for underserved and vulnerable beneficiary populations. **Program Administration-3**: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds. **Program Administration-4**: Increase public knowledge of the financing and delivery of health care. **Program Administration-5**: Improve HCFA's management of information systems/technology.

The HHS Plan also describes many of the collaborative efforts between HCFA and other HHS agencies to achieve the overall mission of HHS. Some examples of these collaborations include:

- In support of Healthy People 2010 goals, the Centers for Disease Control and Prevention and HCFA continuing to work to improve immunization rates in our beneficiary populations (HHS Objectives 3.4 and 4.1).

- The Office of Inspector General, Department of Justice, the Administration on Aging, and HCFA collaborating to fight waste, fraud, and abuse (HHS Objective 3.5).

- The Health Resources and Services Administration, the Department of Education, the Administration for Children and Families, and HCFA partnering to increase Medicaid enrollment and enrollment in the State Children's Health Insurance Program (CHIP) (HHS Objective 3.1).

- The Health Resources and Services Administration and HCFA collaborating to identify ways to better integrate Medicaid, Medicare, and Ryan White Care Act programs to provide HIV health care and support services to people with HIV disease (HHS Objective 3.4).

- The Health Resources and Services Administration and HCFA working together to develop policy related to graduate medical education (GME) and the workforce needs of the health care system. For example, representatives of HRSA and other components within HHS participated with HCFA on the team that developed a proposal to extend payment for GME to non-hospital providers where residents receive training (HHS Objective 3.2).

- The Departments of Labor (DOL) and Health and Human Services (HHS) partnering on the Quality Interagency Coordination Task Force (QuIC). Within HHS, the Agency for Health Care Policy and Research (operating chair of the Task Force) and HCFA are collaborating with DOL on the development and use of: patient/consumer information, key opportunities for quality improvement, measures, workforce to improve quality of care, and information systems (HHS Goal 4).

- The Office for Civil Rights and HCFA working together to ensure that the Medicare, Medicaid, and State Children's Health Insurance Program do not engage in discriminatory actions on the basis of race/ethnicity, national origin, age, sex, or disability. HCFA will continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination (HHS Objective 3.4 and 4.2).

- The Agency for Health Care Policy and Research and HCFA collaborating on the development of a consumer satisfaction survey regarding health plans (CAHPS) (HHS Objective 4.3).

- The Department of Labor, the Treasury Department, and HCFA working together to implement the HIPAA insurance reforms (HHS Objective 3.1).

- The National Institutes of Health and HCFA continuing a long-term partnership to carry out a variety of projects. Two examples include: The joint work between the National Institute of Diabetes, Digestive and Kidney Diseases and HCFA to collect and analyze the United States Renal Data System. The National Cancer Institute and HCFA joint project to develop the SEER cancer registry database (HHS Objective 6.4).

HCFA's Strategic Planning Process

With the publication of its first strategic plan in 1994, HCFA articulated meeting beneficiary needs as a major strategic goal. This goal was understood to encompass not only beneficiary needs for accessible, high quality health care, but also beneficiary needs for prompt and accurate processing of claims and other transactions, information about program benefits, appeal rights, health plans and provider choices, treatment options, and more. In order to achieve our goal of meeting beneficiary needs, HCFA embarked on a comprehensive self-study and consultation process in 1996, which resulted in a restructuring of the Agency in mid-1997. This effort began with extensive analysis and wide consultation with members of the health care and beneficiary communities, Agency employees, representatives of Federal and State agencies and others on the roles HCFA should undertake over the next 5-10 years. Out of this process came a clarified sense of HCFA's "core work" for the future. The emphasis on beneficiary service was renewed and a new theme of "beneficiary-centered purchasing" emerged. HCFA committed to a gradual transformation from its traditional role as payer and regulator of health care providers into a broader role as an active market presence, seeking high value health care for beneficiaries through innovative strategies.

This new sense of direction called for an updated Agency structure, which was put in place nationwide during the summer of 1997. The new structure centers around the Agency's three primary audiences or customer groups—beneficiaries, health plans and providers, and States. For example, the new Center for Beneficiary Services creates a focal point for all of HCFA's interactions with beneficiaries, their families, care givers, and other representatives. The Center for Health Plans and Providers has responsibility for purchasing health care under the Medicare program and serves as the focal point for all programmatic policy and operations issues related to health care plan and provider communities, including both managed care and fee-for-service. The Center for Medicaid and State Operations serves as the focal point for all of HCFA's interactions with States, local governments (including the Territories), and Native American and Alaskan Native tribes.

In order to achieve the vision of beneficiary-centered purchasing, we chose to update our Strategic Plan to be consistent with the new "core work." While not a radical departure from the 1994 Plan, this updated Plan sharpens our focus on beneficiaries and includes the concept of prudent purchasing. It also conveys a heightened emphasis on prevention of waste, fraud, and abuse and HCFA's wider scope of responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA).

In becoming a "beneficiary-centered purchaser" of health care, HCFA will strive to use its market presence to obtain "high value" health care on behalf of our beneficiaries. High value health care is both high in quality and reasonable in cost. That is, HCFA will use purchasing strategies to better meet beneficiary needs, including continued protection of vulnerable segments of the beneficiary population. Some aspects of beneficiary-centered purchasing are already well under way at HCFA (e.g., consumer information initiatives and consumer standards for health plan options) while others would require statutory change (e.g., a streamlined process for excluding providers of substandard care from the programs, more flexible purchasing authority). Many purchasing strategies are presently under development or being tested in demonstration projects around the country. Using waivers of the Medicaid rules, some States are testing promising purchasing approaches that could have broader applicability in the future. The overriding importance of meeting beneficiary needs and the concepts of beneficiary-centered purchasing are reflected in HCFA's mission, vision, and strategic goals and objectives.

Use of Research and Evaluation in Strategic Planning

Evaluation Themes

HCFA performs, coordinates, and supports research and demonstration projects (through intramural studies, contracts, grants, and waivers) to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, Tribes, and other customers and partners. The scope of HCFA's research, demonstration, and evaluation activities embrace all areas of health care relevant to HCFA programs: costs, access, quality, service delivery models, and financing approaches. These research responsibilities include evaluations both of ongoing aspects of the Medicare and Medicaid programs and the State Children's Health Insurance Program, as well as demonstration projects testing new health care financing and delivery approaches. These projects address seven major themes:

- Medicare Health Plans: Enrollment, Delivery, and Payment
- Provider Payment and Delivery Innovations in Traditional Fee-for-Service Medicare
- Research on the Future of Medicare
- Outcomes, Quality and Performance
- Vulnerable Populations and Dual Eligibles
- State Programs
- Research and Demonstration Support Services

Influencing Strategic Planning for Programs and Changing Strategies to Meet Goals

Information gained from evaluation studies plays an important role in planning for the future of HCFA's programs (Exhibit 1). This information has been used to identify critical health care issues and to develop the best available strategies for addressing those issues. HCFA's research and evaluation program produces information and descriptive statistics on the infrastructure of the health system, on populations of health care users, and service and expenditure patterns; examines differences in costs, quality, and access to care; and assesses the effects of HCFA programs on beneficiaries. This information can provide HCFA with pertinent information regarding changes that need to be made in administering our programs.

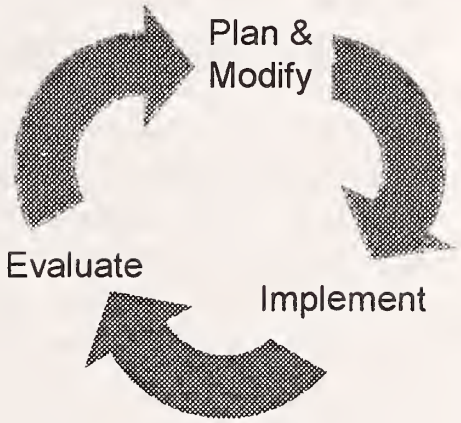

Exhibit 1

For example, evidence from evaluations of the Medicare HMO program indicated that Medicare's cost and risk HMO programs were not achieving intended cost saving objectives. Findings from these evaluations combined with assessments of changes in the health care market led HCFA to focus on being a prudent purchaser of health care as a central theme reflected in the goals and objectives in the Agency's updated strategic plan. HCFA has been investing in the development of improved payment methodologies for managed care, and with the enactment of the Balanced Budget Act of 1997, HCFA is now able to move forward on the development of a new method for paying managed care using risk adjustment for payment rates. Similarly, the new prospective payment systems in BBA for home health agencies, skilled nursing facilities, and hospital outpatient departments all build on the findings from HCFA's research and demonstrations.

Experience under HCFA's "Centers of Excellence" demonstration project provided guidance in HCFA's articulation of its strategic goal, "Purchase the best value health care for beneficiaries." Findings from the project showed that when certain facilities qualifying as "Centers of Excellence" were paid a fee to provide all of the facility, diagnostic, and physician services associated with coronary artery bypass graft (CABG) surgery, Medicare achieved an average of 12% savings for CABG procedures performed through the demonstration.

In addition to evaluation studies, HCFA performs demonstration projects to develop and implement new health care financing policies and to provide information on the impact of HCFA's programs. Results of demonstration evaluations provide HCFA with information about alternative program strategies. This information then is used to plan for the future of our programs. For example, HCFA's demonstration and evaluation of the Program of All-Inclusive Care for the Elderly (PACE) led to the requirement within the Balanced Budget Act to make PACE a permanent part of HCFA's programs. The work under PACE is also an example of how HCFA uses evaluations as part of its strategic planning process to address objectives, in this case, "Improve beneficiary satisfaction with programs, services, and care," and to "Improve access to services for underserved and vulnerable beneficiary populations." Another example of policy and program changes evolving from demonstrations is the creation of the new Children's Health Insurance Program (CHIP). Prior to the creation of CHIP, many States used 1115 demonstrations to expand their Medicaid programs to cover children in families with higher incomes. Despite efforts by States to cover these uninsured children through 1115's, it was determined that over 11 million children were still without health insurance. The Children's Health Insurance Program was created to provide States with additional resources to address the health needs of this population.

HCFA also uses the evaluation work of others such as the Office of Inspector General (OIG), the General Accounting Office (GAO), and the Medicare Payment Advisory Commission (MedPAC, and its preceding entities) in strategic planning. Work of the OIG and GAO is particularly relevant to HCFA's strategic plan goal of "Promote the fiscal integrity of HCFA programs." The collaborative effort of Operation Restore Trust (ORT) by

HCFA, OIG, Medicare contractors, State Medicaid Agencies, Peer Review Organizations, the Administration on Aging, the Federal Bureau of Investigation, and the Department of Justice encompassed a wide range of projects designed to detect and deter home health, skilled nursing facilities, and durable medical equipment waste, fraud, and abuse. ORT is an example of how findings from evaluations have influenced our strategic direction.

Future Program and Demonstration Evaluations

HCFA has planned several future program and demonstration evaluations to assess our strategies and the impact the programs are having on performance outcomes. A schedule of future program and demonstration evaluations is provided in the Appendix. This schedule outlines the main areas of program and demonstration evaluations that HCFA will complete over the next five years and beyond. Most of the areas included in this schedule actually involve several projects that will provide results on the assessment of the programs and demonstrations. In some instances on the schedule, we have listed specific projects as examples. The schedule also shows which HCFA and HHS strategic goals the evaluations support. We would like to point out that nearly all of HCFA's research and evaluation efforts support both HHS Goal 6, "Strengthen the Nation's health sciences research enterprise and enhance its productivity," and HCFA's strategic goal, "Provide leadership in the broader public interest to improve health."

HCFA will use findings from future program evaluations to improve the programs. For example, implementing the Balanced Budget Act provisions will be a major focus for HCFA. Therefore, several evaluations will examine the Medicare+Choice program. Similarly, improving beneficiaries' knowledge and ability to make more informed health care choices, both in the health plans they select and in the services they use, is part of a long-term commitment by HCFA to change and improve communication of information to beneficiaries. HCFA plans to evaluate improved information resources that will enable consumers to choose among health plans and providers based on their relative value and quality.

Findings from our demonstration evaluations will be used to help HCFA plan for the future of the programs and modify strategies for accomplishing

our goals. For example, evaluating the home health agency prospective payment system demonstration and the bundled payment models are key to implementing new prospective payment systems under the Balanced Budget Act of 1997, as well as development of future purchasing methodologies. Therefore, several demonstration evaluations will examine these innovations in provider payments. In addition, certain populations face special challenges in attempting to meet their health care needs. For these vulnerable groups, new approaches are needed to address issues of access and the appropriateness of existing delivery systems and financing. Thus, several demonstration evaluations will focus on HCFA's vulnerable and dual eligible populations. Finally, future findings from the 1115 waivers in the Medicaid program may provide HCFA with additional insight on pertinent issues in the Medicaid population.

Relationship Between the Strategic Plan and the Annual Performance Plan

HCFA's Performance Measurement Philosophy

HCFA's performance measurement philosophy grows out of our overriding commitment to meeting beneficiary needs and securing high value health care on behalf of beneficiaries. Because of the character of its programs, HCFA uses a balanced approach that addresses the core of program performance through the use of beneficiary-related measures and also includes specific key measures related to administrative functions. Given the nature and size of HCFA's programs, the approach to performance measurement includes a strategy of selecting performance goals that are not only significant, but also broadly representative of program performance. This "marker" approach seeks key factors that can be used as indicators of program performance. In short, HCFA's measurement philosophy has two elements. First, we believe that the most important things to measure relate to assuring that the beneficiaries of HCFA programs receive the high quality care they need. Second, because of the enormous scope of HCFA programs, we will pursue goals that are representative of program performance.

The Conceptual Framework

HCFA's performance goals are grouped into three "levels": (1) core beneficiary goals, (2) beneficiary-related goals, and (3) administrative output goals (Exhibit 2).

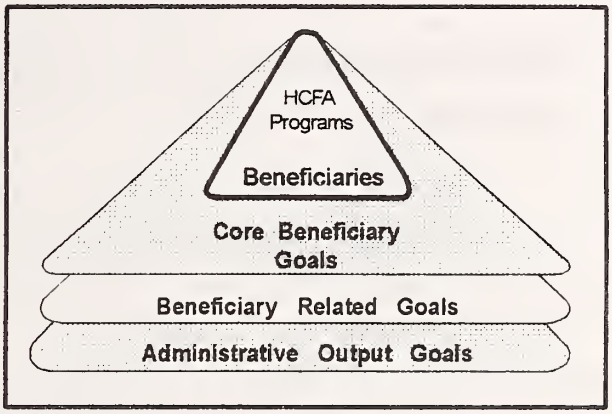

Exhibit 2

Central to performance measurement for HCFA is the beneficiary focus that pervades our strategic goals and objectives. Performance goals that are most closely aligned with beneficiaries, and thus are more outcome oriented, are at the core of the Agency's approach to performance measurement. This core consists of measures of beneficiary access to care, beneficiary satisfaction, and measures of the quality of care that beneficiaries receive. HCFA directly measures beneficiary access to care and beneficiary satisfaction, as perceived by beneficiaries themselves. As core measures connected to fundamental program purposes, beneficiary satisfaction, access, and quality of care will be enduring performance measures.

A second level of performance goals supplements the core beneficiary-centered measures. This second level consists of measures that are closely related to beneficiaries and in some cases are considered proxies for the core beneficiary-centered measures. Again, because of the connection to beneficiaries, the measures in this second level are considered important indicators of program performance. The third level of performance goals rounds out HCFA's approach by incorporating goals (generally output measures) that are more closely aligned with administrative and program development functions.

This tri-level approach to performance measurement provides comprehensive coverage, using a balancing among types of measures connecting to the Agency business activities. HCFA believes it is important

to articulate and measure performance goals at each of these three levels. This approach relies on identifying a set of significant meaningful performance measures that speak to both fundamental program purposes, but also incorporate key output-oriented measures that tie to administrative activities.

The beneficiary-centered core and beneficiary-related performance goals are primarily related to HCFA's strategic goals:

- Protect and improve beneficiary health and satisfaction.
- Purchase the best value health care for beneficiaries.
- Promote beneficiary and public understanding of HCFA and its programs.

The administrative performance goals in general are most closely aligned with HCFA's strategic goals:

- Promote the fiscal integrity of HCFA programs.
- Foster excellence in the design and administration of HCFA's programs.
- Provide leadership in the broader public interest to improve health.

Achievement of Strategic Goals

Achievement of our strategic goals and objectives is assessed through our performance goals. Some of the performance goals will take several years to achieve and thus will use a multi-year target with interim annual targets for purposes of the Annual Performance Plan. Other performance goals will involve single year targets only. Specific details about the HCFA performance goals may be found in our Annual Performance Plans. Here we provide the overview framework for assessing our achievements related to the Strategic Plan Goals.

Protect and improve beneficiary health and satisfaction—Measures of beneficiary satisfaction, access to care, and quality of care will be the major focus for monitoring this strategic goal.

Promote the fiscal integrity of HCFA programs—Progress on this goal will focus on the major areas of monitoring our financial management systems and tracking our efforts to address program integrity.

Purchase the best value health care for beneficiaries—Performance measurement during the time period covered by this Strategic Plan will examine our progress in improving health plan choices available to beneficiaries, evaluating the implementation of the Medicare+Choice program, and tracking our implementation of new payment systems.

Promote beneficiary and public understanding of HCFA and its programs—Performance measurement related to this goal will track our progress in effectively providing information about our programs to beneficiaries, in improving knowledge of our programs, and improving our customer service. For example, attention will be placed on evaluating HCFA's consumer information efforts related to Medicare+Choice.

Foster excellence in the design and administration of HCFA's programs—Performance measurement will focus on monitoring progress related to improvements in the management of our information systems and technologies, including tracking our progress on millennium compliance. Because of the inherent relationship between our goals of excellence in design and purchasing the best value health care, performance goals related to improving payment systems will also be of relevance to measuring our progress on our goal to foster excellence in the design and administration of HCFA's programs.

Provide leadership in the broader public interest to improve health—This goal highlights the leadership role we are striving to play in the larger health care system. Our performance measurement related to this goal will track our progress on activities that affect more than just the Medicare, Medicaid, and State Children's Health Insurance programs. Performance measures related to this goal will focus on HCFA's activities in the broader health system including for example, health insurance regulatory responsibilities under HIPAA, clinical laboratory responsibilities under CLIA, and HCFA research.

Mission and Vision Statements

HCFA's mission states a concise view of what we are about. Our vision depicts what we aspire to do in the future.

Mission

"We assure health care security for beneficiaries."

Health care security means:

- Access to quality health care services that are affordable to beneficiaries;
- Protection of the rights and dignity of beneficiaries; and,
- Provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

Vision

"In the stewardship of our programs, we lead the Nation's health care system toward improved health for all."

The Vision reflects our commitment that:

- In cooperation with States and other partners, we will strive toward the best possible health outcomes for the programs' beneficiaries.
- We will purchase health care for our beneficiaries that represents "best value"—high quality care at the best possible price.
- We will use our market presence as the Nation's largest purchaser of health care to promote continuous improvement in both quality and value throughout the health care system.

Strategic Goals

The heart of the Strategic Plan is the statement of our primary strategic goals—that short list of our major emphases over the next several years. These goals represent not only our understanding of the Agency's statutory responsibilities, but our broader sense of purpose and direction informed by a common set of Agency values.

- Protect and improve beneficiary health and satisfaction.
- Promote the fiscal integrity of HCFA programs.
- Purchase the best value health care for beneficiaries.
- Promote beneficiary and public understanding of HCFA and its programs.
- Foster excellence in the design and administration of HCFA's programs.
- Provide leadership in the broader public interest to improve health.

Objectives and Strategies

In order to achieve our strategic goals, we have developed a set of more specific objectives that support those goals. The strategic goals are interdependent, therefore the objectives support multiple goals. Thus, we have not associated objectives directly with goals. We have grouped the objectives into three broad functional categories:

- Customer Service;
- Quality of Care; and
- Program Administration.

Under each objective we have listed possible "strategies" that could be used to help us achieve that objective. These strategies are illustrative and intended to help further understanding of the objectives. Some strategies overlap. Some strategies may not prove practical upon closer examination and may need to be refined or even eliminated. Some strategies listed are already well under way, others require legislative change.

Customer Service (CS) - Objectives and Strategies

CS-1: Improve beneficiary satisfaction with programs, services, and care.
• Measure beneficiary satisfaction with all aspects of care, including access, using a multi-dimensional instrument such as the Consumer Assessment of Health Plan Study (CAHPS). • Conduct demonstration projects on innovative ways to meet beneficiary-expressed needs and to deliver high value health care services. • Collect, analyze, and act on information with respect to beneficiary needs, complaints, and satisfaction. • Develop and implement creative customer service strategies for HCFA programs. • Collaborate with public and private health and human services organizations to better serve our beneficiaries. • Implement a public education program to enable beneficiaries to become active, informed participants in their health care choices. • Expand choices available to Medicare beneficiaries through implementation of the Medicare+Choice program created by the BBA and other strategies.

Customer Service (CS) - Objectives and Strategies

CS-2: Enhance beneficiary program protections.
• Increase beneficiary access to information to enable them to make sound health care decisions and, when appropriate, to exercise their grievance and appeal rights. • Take aggressive action in collaboration with other HHS components to preserve and strengthen consumer protection and quality enforcement and non-discrimination in our programs to resolve issues of potential harm to our beneficiaries. • Champion beneficiaries' views and needs in the development and operation of health and benefit programs and policies. • Require Medicare+Choice organizations contracting with HCFA to meet prescribed standards for grievance and appeal processes, with respect to providing information on appeal rights and procedures, timely processing of complaints, and positive resolution of beneficiary concerns. • Enforce and monitor compliance with the Consumer Bill of Rights and Responsibilities.

Customer Service (CS) - Objectives and Strategies

CS-3: Increase the usefulness of communications with beneficiaries.

- Improve the two-way communication channels with beneficiaries to assess and understand their health care and benefit needs.
- Provide beneficiaries useful and unbiased information to assist them in making informed choices among alternatives for supplemental insurance coverage, health plans and providers, treatment options, and healthy behaviors.
- Assess HCFA's current methods of information dissemination by conducting focus groups, surveys, and questionnaires of beneficiaries.
- Provide easy access to information in a clear, culturally, and linguistically competent manner and in a variety of formats that recognize the needs of the diverse populations we serve. This includes providing useful information for sensory impaired individuals and limited English proficiency (LEP) persons.
- Build coalitions at the community, State, and national levels to anticipate and respond to changing information needs of our diverse beneficiary populations and the public.
- Work with States on increasing beneficiary access to information around the Medicaid and CHIP programs.
- Work with constituent communities to build understanding of HCFA's information resources.

Customer Service (CS) - Objectives and Strategies

CS-4: Increase the usefulness of communications with constituents, partners, and stakeholders.
• Improve the utility and accessibility of information about HCFA's programs and health care delivery systems. • Provide health plans and providers, contractors, States, and other partners timely, accurate, and complete information and other necessary assistance to support their work in service to HCFA program beneficiaries. • Establish and maintain communications with Tribal and other American Indian/Alaska Native (AI/AN) organizations; ensure that the Tribes are informed of proposed changes; seek input from Tribes in areas where changes to our programs have potential impact to the AI/AN community. • Formulate communication strategies to meet the needs of the public and evaluate the effectiveness of those strategies. • Establish communication standards to ensure timely and consistent access to comparative information on HCFA programs and health delivery system options. • Apply technological innovations as a means to reach our constituents, partners, and stakeholders. • Contribute information about the health care system from HCFA's perspective and participate in national health care discussions. • Establish mechanisms to increase the usefulness of HCFA's Internet home page through activities such as expanding content and establishing additional links from other sites.

Customer Service (CS) - Objectives and Strategies

CS-5: Ensure that programs and services respond to the health care needs of beneficiaries.
• Educate beneficiaries about the role of preventive services such as immunizations and screening mammograms and appropriate self-care. • Educate health care consumers to seek high quality, cost effective health care. • Encourage the appropriate use of home and community-based services as an alternative to institutional care. • Implement program demonstrations of more flexible delivery, payment, and coverage approaches to better meet beneficiaries' needs; seek legislation to implement the most successful approaches. • Seek legislative and public policy changes that improve HCFA's programs when appropriate.

Quality of Care (QC) - Objectives and Strategies

QC-1: Improve health outcomes.
• Establish and announce specific beneficiary outcome priorities. • Analyze opportunities to improve care for specific outcome priorities, and implement specific intervention strategies. • Establish and enforce performance standards for providers, that are more outcome-oriented, provide related technical assistance, and provide incentives for desired performance. • Provide consumers with assistance and information to support informed choices with respect to treatment options, providers, insurance plans, etc. • Make quality-oriented payment and coverage policy decisions based on the best evidence available. • Take aggressive action to remove access barriers that prevent achievement of specific outcome priorities. • Assess the quality impact of interventions for improvement to determine whether they should be continued, modified, or withdrawn. • Promote wellness by educating beneficiaries about health promotion and disease prevention. • Support quality improvement initiatives by collaborating with HHS Agencies and other purchasers and beneficiary groups on standards and strategies for improving health care. • Collaborate with others in the public and private sectors on standards and technologies to improve the accessibility and usability of health care information.

Quality of Care (QC) - Objectives and Strategies

QC-2: Improve access to services for underserved and vulnerable beneficiary populations.
• Improve surveillance tools used to identify potential access problems among underserved and vulnerable populations. • Use surveillance information to target interventions toward improving access to necessary care. • Investigate new health care delivery models that serve diverse populations (e.g., the disabled, people with AIDS, inner city/urban residents, non-English speaking persons, American Indians/Alaska Natives, the chronically ill); seek legislation to implement successful approaches. • Foster services such that they are provided in a culturally and linguistically competent manner. • Increase enrollment of Medicaid-eligible individuals and enroll eligible children in the State Children's Health Insurance Program by working with States and other public agencies to design and carry out outreach activities. • Increase enrollment of the dual eligible population in the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Beneficiary (SLMB) programs and improve coordination of care and benefits for dually eligible beneficiaries. • Foster community-based partnerships to address the needs of underserved populations. • Monitor utilization and financial status of safety net providers (those serving the most needy and vulnerable) in anticipation of possible lapses in access to service. • Promote access and portability in the private health insurance market consistent with the provisions of HIPAA.

Quality of Care (QC) - Objectives and Strategies

QC-3: Protect beneficiaries from substandard care.
• Develop appropriate performance measures and uniform data collection and reporting to support performance evaluation. • Collect data that objectively assess providers' and plans' conformance with established clinical standards and expectations and publish comparative aggregate data on performance. • Rapidly exclude substandard providers, suppliers, laboratories, and health plans from our programs, using all legal remedies available. • Assist providers, plans, States, Tribes, beneficiaries, and their advocates by providing performance information, guidelines, benchmarks, and improvement strategies. • Investigate complaints of poor quality care, including failure to provide needed care, in a timely manner. • Strengthen oversight and enforcement of provider conditions of participation. • Work with States to improve inspections of and quality of care delivered in nursing homes.

Program Administration (PA) - Objectives and Strategies

PA-1: Build a high quality, customer-focused team.
• Ensure the workforce has the opportunities—e.g., training, access to information, and tools—to obtain and maintain professional competencies. • Create an environment which is conducive to recruiting, hiring, valuing, and retaining a highly competent workforce that understands our customers and responds to their needs. • Create an environment that ensures a high quality of work life including: improving communications among all employees, increasing investment in workplace learning, strengthening diversity management practices, being sensitive to and valuing diversity in the workforce, and strengthening employee-centered programs.

Program Administration (PA) - Objectives and Strategies

PA-2: Enhance program safeguards.

- Take aggressive action to minimize waste, fraud, abuse, and error in the administration of HCFA's programs (e.g., work to reduce the percentage of improper payments made for Medicare home health services).
- Improve the payment safeguards to ensure that claims, health plans, and States are paid correctly the first time; implement the Medicare Integrity Program to provide tools and resources for enhanced program integrity efforts.
- Expand the partnership approach in which HCFA works with relevant Federal agencies, including the OIG, DOJ, and AOA, and State agencies to identify and resolve patterns of program waste, fraud, and abuse.
- Maintain a management control system to identify risks and vulnerabilities.
- Ensure that the costs of health care services are shared appropriately as specified in law, regulations, and related instructions.
- Identify providers and plans in violation of financial conflict of interest standards and take corrective action.
- Provide effective financial oversight of HCFA programs.
- Provide beneficiaries with more effective tools to identify and report suspected waste, fraud, and abuse.

Program Administration (PA) - Objectives and Strategies

PA-3: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds.
• Conduct comprehensive evaluations of program operations to identify and improve program efficiency and customer satisfaction. • Establish clear expectations of desired program outcomes, evaluate current performance against the desired outcomes, and take actions based on evaluation of the gap. • Provide timely information to Congress on the financing implications of proposed legislative changes to HCFA programs including working with the Medicare Trustees to report on the financial status of the Medicare program. • Sponsor a variety of public forums, discussions, and seminars with our beneficiaries and partners to periodically assess and review HCFA's program performance. • Develop, test, and implement flexible and innovative approaches to purchasing health care services, including implementing the prospective payment systems and risk adjustment authorized by the Balance Budget Act of 1997. • Promote value-based decisions regarding health care services (value means optimizing clinical efficacy, cost, beneficiary satisfaction, and well-being). • Ensure that provider and plan payment schedules and rates accurately reflect the appropriate payment for services rendered. • Work in partnership with the HHS Office for Civil Rights to identify and resolve incidents and patterns of civil rights discrimination in programs receiving funds from HCFA. • Assess and improve overall effectiveness and quality of Medicare contractor performance. • Seek legislation to reform Medicare fee-for-service contracting authorities to improve program management and customer service. • Enhance HCFA's environmental scanning to help determine future directions for HCFA programs.

Program Administration (PA) - Objectives and Strategies

PA-4: Increase public knowledge of the financing and delivery of health care.
• Conduct research on health care financing, delivery, and quality measures and disseminate findings to the research community, policy-makers, and the public through appropriate channels. • Produce and disseminate estimates of national health care expenditures. • Monitor insurance coverage across beneficiary population groups. • Conduct demonstration projects to test alternative financing and delivery strategies.

Program Administration (PA) - Objectives and Strategies

PA-5: Improve HCFA's management of information systems/technology.

- Establish a HCFA investment review process to enhance the value of HCFA's major information systems/technology (IS/T) investments.
- Ensure the continuity of Medicare claims processing and other computer systems beyond the Year 2000.
- Increase user satisfaction with access, reliability, and accuracy of program and administrative data.
- Provide leadership in defining, developing, implementing, and maintaining uniform data standards for the exchange of health care information in our programs, as well as across the Nation's health care system.
- Work with constituent communities to develop performance standards to evaluate the access to and quality and usefulness of HCFA's program data and implement strategies to provide training to users on HCFA data.
- Develop and implement cost-effective strategies for data collection, storage, transmission, management, security, and privacy.
- Exercise leadership in health care data management and utilization.
- Create the infrastructure necessary to realize increased claims processing efficiency, improved ability to safeguard the program from waste, fraud, abuse, and error, and to support health care quality measurement and improvement.

Operating Principles

As an adjunct to our Strategic Plan, we developed a set of "operating principles" for the Agency to clarify for ourselves and others how we need to operate in order to achieve our goals and objectives. In other words, the goals and objectives state what we aim to achieve as an agency and the operating principles state how we will work together to get there. These principles affirm that HCFA is committed to a culture that will support its mission.

Our Beneficiary Focus

- We will act based on the knowledge that beneficiaries are our primary customers and that HCFA's "reason for being" is to understand and respond to beneficiaries' needs—for health care, for program-related information, and for prompt, courteous service.

- We will use our market presence to actively seek high value health care for beneficiaries—high quality, cost-effective care—and encourage other purchasers of care to do the same.

- We will work toward the highest standards of service to beneficiaries, their families, and the public, providing clear information, prompt and accurate processing of claims, appeals, and correspondence.

- We will act, with appropriate partners, to help assure that beneficiaries receive equitable and nondiscriminatory services.

How We Work with Others in the Health Care System

- We will strive to be an even-handed and reliable business partner with plans, providers, States, contractors, and other stakeholders in our programs.

- We will work collaboratively with our colleagues throughout the Federal government, in the States and territories, Tribes, in accrediting bodies, beneficiary and provider advocacy groups, and elsewhere, to achieve mutual goals.

- We will demonstrate leadership in the public interest, consistent with our position as the largest public or private purchaser of health care in the United States, including the effective use of our vast administrative and clinical data resources to improve health outcomes and service to the public.

- We will build on our record of successful implementation of legislated program changes to become more flexible and responsive to other changes in the health care environment.

How We Operate Within HCFA

- HCFA staff operate as members of the same team, with a common mission, and each with a unique contribution to make to our success.

- We will be open to new ways of working together, including creating project teams within and across components including Regional Offices, more co-locating of support personnel with the units served, and using multi-disciplinary approaches to tasks.

- We will become more consistent in our use of qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time.

How We Want to be Recognized by Our Customers, Partners, and the Public

- We want to be recognized as the champion of HCFA program beneficiaries.
- We want to be recognized as an effective and efficient administrator of programs and a good steward of the funds entrusted to us by the taxpayers.
- We want to be recognized as a leader in the health care system, working toward access to high quality, high value health care for all.

Appendix - Schedule of Future Evaluations

Schedule of Future Program Evaluation Areas[1]		
Project, Methods, Scope, and Key Issues	**HCFA Goal[2]**	**HHS Goal[3]**
Medicare+Choice Plans: Monitor and evaluate the implementation of the Medicare+Choice program; assess responses of health plans to new capitation rates and eligibility requirements; assess responses of beneficiaries to changes in health plans and benefit packages; continue to evaluate HMO performance by studying enrollment patterns, selection bias, disenrollment, beneficiary satisfaction, and quality; continue to improve risk adjustment methods. *Enrollment in Medicare+Choice Plans:* Monitor enrollment across different types of Medicare + Choice plans. The analyses will focus on sources of enrollees (other plans or FFS) and the selection bias among types of plans and between plans and FFS sector. This project aims to understand the impact on program expenditures of increasing health plan options available to Medicare beneficiaries. [Estimated completion 1999] *Monitoring/Evaluating Medicare+Choice:* Evaluate BBA provisions: Responses of health plans to new capitation rates and eligibility requirements; responses of beneficiaries to changes in health plan offerings, including introduction of new types of plans; impact on selection bias; impact on private market.	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs. Goal 4 - Improve the quality of health care and human services.

[1] This schedule is an overview of the program and demonstration evaluations that HCFA intends to carry out. A detailed list of all evaluations or additional information about these evaluations may be obtained by contacting HCFA's Office of Strategic Planning.

[2] Nearly all of HCFA's research and evaluation efforts support HCFA's Strategic Goal, "Provide leadership in the broader public interest to improve health."

[3] Nearly all of HCFA's research and evaluation efforts support HHS Goal 6, "Strengthen the Nation's health sciences research enterprise and enhance its productivity."

Schedule of Future Evaluations

(con't.)

Schedule of Future Program Evaluation Areas		
Project, Methods, Scope, and Key Issues	**HCFA Goal**	**HHS Goal**
Beneficiary Information Needs: BBA mandates broad beneficiary information and education programs to be initiated during annual open enrollment periods. Supporting research is needed to evaluate the effectiveness of these new initiatives, and to refine/improve future efforts. Specific projects would include a national baseline survey of current Medicare beneficiary knowledge of specific, important aspects of the Medicare program. From this baseline information, improvements in Medicare beneficiaries' understanding of important Medicare concepts could be measured.	Protect and improve beneficiary health and satisfaction. Promote beneficiary and public understanding of HCFA programs.	Goal 4 - Improve the quality of health care and human services.
Development and Assessment of Performance Measures: Develop and assess the surveys that will be used to measure the performance of health plans; specifically, evaluate the Kansas City pilot test of the CAHPS.	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs. Goal 4 - Improve the quality of health care and human services.
Acute Care Services: Report to Congress on the Impact of Physician Payment Reform on Utilization and Access to Care—This Report to Congress involves integrating aspects of access-related work including data from the physician monitoring system, physician supply files and others into the annual report to Congress on the Medicare physician fee schedule.	Protect and improve beneficiary health and satisfaction.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

Schedule of Future Evaluations

(con't.)

Schedule of Future Program Evaluation Areas		
Project, Methods, Scope, and Key Issues	**HCFA Goal**	**HHS Goal**
Health Status, Outcomes, and Costs: Evaluate the outcomes and costs of alternative treatment patterns for specific diseases and procedures; monitor immunization rates and utilization rates of other preventive services.[Ongoing evaluation]	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs. Goal 4 - Improve the quality of health care and human services.
Medicaid Program Studies and Evaluation: Evaluation of Medicaid 1915(c) waiver program (home and community based waivers). Understand the impact of the 1915(c) waiver program and make recommendations to expand and enhance the program. Evaluation of Medicaid 1115 waivers (State Health Reform Demonstrations). Provides information on impacts of State health reform initiatives.	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries. Foster excellence in the design and administration of HCFA's programs.	Goal 2 - Improve the economic and social well-being of individuals, families, and communities in the United States. Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.
Maternal and Child Health Research: Evaluate the effects of the OBRA89/90 Medicaid coverage expansions for pregnant women and children.	Protect and improve beneficiary health and satisfaction.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

Schedule of Future Evaluations

(con't.)

Schedule of Future Program Evaluation Areas		
Project, Methods, Scope, and Key Issues	**HCFA Goal**	**HHS Goal**
Welfare Reform and State Children's Health Insurance Programs (CHIP): Develop data sets to track the effects of welfare reform on trends in Medicaid coverage; develop data sets to track the effects of CHIP; partner with SSA to identify immigrants, disabled children, and alcohol and drug abusers who lose Medicaid coverage as a result of welfare reform to determine the extent to which they regain Medicaid coverage through alternative programs.	Protect and improve beneficiary health and satisfaction.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.
Peer Review Organization (PRO) Program: Evaluate the impact of the PRO program on the quality of care delivered to Medicare beneficiaries.	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries. Foster excellence in the design and administration of HCFA's programs.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs. Goal 4 - Improve the quality of health care and human services.
Health Insurance Portability and Accountability Act of 1996 (HIPAA): Design a data strategy for identifying the persons who are affected by HIPAA provisions; evaluate whether HIPAA raises the cost of insurance to the affected persons; evaluate the impact of the mental health parity provision.	Provide leadership in the broader public interest to improve health.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

Schedule of Future Evaluations

(con't.)

Schedule of Future Demonstration Evaluation Areas[1]		
Project, Methods, Scope, and Key Issues	**HCFA Goal[2]**	**HHS Goal[3]**
Medicare Health Plan Delivery and Payments: *Medicare Capitation Demonstrations:* Implement and evaluate demonstrations involving various applications of capitated payment—medical savings accounts, competitive pricing and coordinated open enrollment demonstration, third party enrollment demonstration, subvention demonstration, and Medicare Choices demonstration. *Medicare Capitation Models that Integrate Acute and Long Term Care Services*: Implement and evaluate demonstrations in which Medicare's capitated payment covers both acute and long term care services—Social HMO, Evercare, PACE.	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries. Foster excellence in the design and administration of HCFA's programs.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

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Schedule of Future Evaluations

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Schedule of Future Program Evaluation Areas		
Project, Methods, Scope, and Key Issues	**HCFA Goal**	**HHS Goal**
Provider Payment and Delivery Innovation in Traditional Fee-for-Service Medicare: *Bundled Payment Models:* Evaluate demonstrations that make an all inclusive payment for hospital and physician services for specific inpatient episodes of care—Medicare Provider Partnerships, Medicare Participating Centers of Excellence, and Medicare Participating Heart Bypass Centers. *Acute Care Services:* Evaluate the New York graduate medical education payment alternative demonstration, competitive pricing demonstration for durable medical equipment, competitive bidding for part B services demonstrations, Medicaid drug use review (DUR) demonstration that tested the effect of an online prospective drug utilization review system. *Post Acute Care Services:* Evaluate the home health prospective payment demonstration. *Telemedicine:* Evaluate rural telemedicine demonstration projects; monitor and analyze effects on utilization patterns and program expenditures.	Purchase the best value health care for beneficiaries. Foster excellence in the design and administration of HCFA's programs.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

Schedule of Future Evaluations

(con't.)

Schedule of Future Program Evaluation Areas		
Project, Methods, Scope, and Key Issues	**HCFA Goal**	**HHS Goal**
Vulnerable Populations and Dual Eligibles: *Vulnerable Populations Research & Demonstrations:* Evaluate the ESRD managed care demonstration; design a study to analyze reasons for barriers to care among vulnerable populations. *Consumer Choice Projects:* Evaluate the durable medical equipment consumer direct purchasing demonstration. *Integrating Medicare and Medicaid for Dually Entitled Beneficiaries*: Evaluate the impact of 1115 demonstrations on the dually eligible population. *Medicaid Managed Care Demonstrations and Evaluations:* Evaluate the State health reform demonstrations to assess effects of the shift to managed care, the use of carve outs for mental health and AIDS services (protease inhibitors), and eligibility extensions.	Protect and improve beneficiary health and satisfaction. Purchase the best value health care for beneficiaries.	Goal 3 - Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs. Goal 4 - Improve the quality of health care and human services.

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